Chapter 16

MENTAL HEALTH

16.1. Definition. In the DIHS medical program, the term ”mental health” provider will apply to a psychiatrist, a psychologist, or a licensed clinical professional counselor.

16.2. Mental Health Screening. The Mental Health Screening Form (DIHS 843) shall be completed for all detainees who will be housed in an INS SPC, contract detention facility or jail, for more than 24 hours. This form is to be completed during the intake screening process by a medical provider.

16.2.1. Procedure. The detainee may complete the Mental Health Screening Form if he/she can read and write. If not, it shall be completed by a medical provider.

X The medical provider will review the Mental Health Screening Form for any positive responses. If any of the questions have a “yes” answer, the Screening Form will be given to the Clinical Director for review.

X The Clinical Director will then have the option to refer the detainee to a mental health provider for further evaluation.

16.3. Mental Health Care. Upon clinical screening or examination, any detainee suspected of being mentally ill or mentally retarded (developmentally disabled) shall be referred to a Mental Health Provider for evaluation and/or treatment.

16.3.1. Crisis Management. A detainee should be evaluated immediately if they are a danger to themselves or others. Upon reaching the conclusion that no other less restrictive treatment is appropriate, the DIHS physician or mental health provider may make the decision to chemically restrain a detainee. The use of forced psychotropic medications must follow the National Commission on Correctional Health Care guidelines (J-65) and the Joint Commission on the Accreditation of Health Care Organizations guidelines. Refer to policy 16.7 for use of therapeutic restraints. Arrangements should be made to transfer the patient to an acute care facility as soon as possible. For facilities with short stay units, the acute patient may be placed in the unit until arrangements can be made for transfer but should not be managed in the unit.

16.3.2. Management Of Symptomatic Mental Health Patients. A detainee presenting symptoms consistent with a mental problem regardless of prior history of a mental health condition, should be seen by a mental health provider as soon as possible or by a physician, if a mental health provider is not immediately available. If it is determined that a detainee is in need of antipsychotic medications, the patient must be seen by a psychiatrist.

16.3.3. Management Of Asymptomatic Mental Health Patients. A detainee presenting at intake screening with a prior history of a mental health condition and who is stable on medication, should be scheduled to see a mental health provider within 14 days. A physician should arrange to continue medications until the detainee is evaluated by the mental health provider. If a physician is unavailable an NP/PA is authorized to continue medications until a physician can see the detainee.

The physician should see the detainee the next regular working day to ensure that there are no breaks in the treatment. Once a detainee is evaluated by a mental health provider who is not a psychiatrist and it is determined that medications should be continued, the detainee must be seen by a psychiatrist unless the detainee falls under the crisis management classification.

16.3.4. Continuity Of Mental Health Care. Scheduled follow-up visits with the mental health provider should be based on the detainee's mental status, response to medications, progress with psychotherapy, and/or need for changes in the treatment plan. Treatment plans that do not involve medications do not require follow-up with a psychiatrist. If the treatment plan requires addition or changes in medications, the change must be made by a psychiatrist. The detainee will be seen by the Mental Health Provider/Physician/NP/PA for management and medication renewal at least every 30 days. If the follow-up is performed by a psychologist, the physician will renew the medication. If a detainee is undergoing mental health care in a facility that does not have an on-site mental health care provider and where the follow-ups are being performed by the physician or NP/PA, then the detainee must be seen by a mental health provider at least every 90 days.

16.3.5. Medications. All psychotropic medications, controlled substances, and other categories of mediations given for mental health purposes must be placed on the pill line.

16.4. Informed Consent for Medications. Informed consent must be obtained from the detainee before any medications are administered for mental health treatment. The purpose of the consent is to ensure the detainee is told the name of the medication, its prescribed dose and schedule, what it is for, and the possible effects. A consent must be obtained for each classification of medication utilizing the appropriate DIHS 844 consent form.

16.5. Forensic Mental Health Evaluations. Forensic mental health evaluations are evaluations requested by the Court System for use in adversarial proceedings to determine a legal question. Determination of competency is considered a forensic evaluation. Detainees requiring forensic mental health evaluation shall be referred off-site to a non-DIHS psychiatrist, who is not involved in a therapeutic relationship with the detainee. The evaluation shall be completed using the following forensic mental health evaluation format. Other mental health evaluations and assessments may also follow this format but do not need to use every step.

16.5.1. Establishing a Diagnosis. Clinical diagnosis follows criteria specified in the most current edition of the American Psychiatric Association Diagnostic and the Statistical Manual of Mental Disorders (DSM). Recommendations for ongoing clinical management or treatment will be made. If no evidence of a mental disorder is found, it shall be noted in the written report. Each mental disorder diagnosis shall be documented with written evidence of the criteria as listed in the DSM. If a diagnosis of mental retardation or borderline intellectual functioning is established, the psychological test(s) and full-scale score with a 90 percent confidence interval shall be provided.

16.5.2. Report Format. The written report shall be prepared in the following format:

X**Detainee Identification**: Detainee's full name, alien number, date of birth, age, gender, education level, former occupation (and any present work assignment in the facility), marital status, ethnic origin, date of evaluation, identity of the current facility, and date of arrival at current facility.

Requestor and Reason for Evaluation: Reasons for an evaluation may include but are not limited to: periodic reevaluation; determination of current mental status; and psychological testing to determine general cognitive functioning, or to determine the potential for violence or suicide. Additionally, any problems indicated by the detainee should also be included.

The following are examples of statements that should be included in all reports, for the purpose of identification of requestors and for the reason for the evaluation:

Example (1) "Mr/Ms. _____ _____, A#_____, was seen at the request of His Honor Gomer Smith, Federal District Court Judge of the Southeastern District of Oklahoma for determination of Mr/Ms. _____'s ability to understand the proceedings of the court and to aid in his defense."
Example (2) "Mr/Ms. _____ __, A# _____, was seen at the request of Mr. _____ _____, OIC of _____ of the Immigration and Naturalization Service for a mental competency evaluation. This is a periodic re-evaluation."

XFamily and Social History***:*** This section should include available information concerning the family of origin, education, work history, psychosexual history, military, and legal history. If this information is accurately reported and reflected in previous document copies, it may be attached to the evaluation so that they do not need to be replicated in the evaluation report. These documents may be referred to for example by stating, " For complete family of origin history and social history, see the attached report of Dr. _____ _____ at tab 'C'."

XMental Health History: This section of the evaluation shall include all known reports of hospitalization, detention history, and any previous psychological evaluations that have been completed on the detainee. If this data is accurately reflected in previous documents, it may be attached to the evaluation. For example: "For psychological history see the attached report of Dr. _____ ____ at tab 'C'."

XMedical History: This section of the evaluation shall include known medical problems, especially those that may have a bearing on the mental status. Additionally, current and past medications, known drug allergies and reactions, any history of cerebral trauma, or seizures is noted here. If a complete medical history has been obtained, it may be attached to the report. For example: "For medical history see the attached report of Dr. _____ _____ at tab 'C'."

XHistory of Alcohol and Substance Use: This section shall summarize a history of all alcohol and substance abuse/dependence and past treatment if any.

XDevelopmental History: This section shall summarize all known educational, legal problems including sex offenses, and history of victimization due to criminal violence.

XMental Status Examination: This section of the evaluation shall include the general appearance of the detainee at the time of the assessment, as well as behavior, mood/affect, orientation, stream of speech and thought, any special preoccupations, presence of delusions, hallucinations, thought content, judgment, abstract thinking, memory, presence of suicidal / homicidal ideas or intentions with estimation for potential of expressive violent behavior, and an estimate of general cognitive functioning. It will also include current emotional response to incarceration.

XOther Observations: This section shall summarize the results of all psychological tests administered.

XFormulation: This section is a general summary of the evaluator's observations concerning this case.

XClinical Impression: All five axises shall be used. The evaluator shall refer to the most recent edition of the DSM.

Axis I - Clinical Syndrome and V Codes. Provide the clinical diagnosis along with the list of criteria used to establish the diagnosis. If there is a degree of professional judgment questioning a diagnosis, it should be noted by placing the word "Provisional" after the diagnosis.

Axis II - Developmental and Personality Disorders. Provide diagnoses along with a list of the criteria used to establish each diagnosis. If there are no Axis II diagnoses use 'V71.09 No diagnosis'. A list of personality traits may be included (example: "antisocial personality traits"). If there is some professional judgment questioning a diagnosis it should be noted by placing the word "Provisional" after the diagnosis.

Axis III - Physical Disorders and Conditions. Identify known physical disorders and conditions. If there are none it should be noted (see medical history).

Axis IV - Severity of Psychosocial Stressors. These shall be identified as outlined in the most recent edition of the DSM.

Axis V - Global Assessment of Functioning. There shall be two assessments made on this axis. The first assessment is the GAF reflecting the current functioning level. The second assessment is the estimated highest level of functioning for the detainee during the past year.

XRecommendations for Treatment: Recommendations need to be as specific as possible. The type, frequency, duration and setting for the treatment should be included.

XRecommendation for Further Evaluation: State the need for any additional psychological testing that was not completed.

XStatement of Competence: If no further evaluation is required, the following statement may be used: "On the basis of the psychological examination and evaluation of available information at this time, the patient possesses [does not possess] sufficient mental capacity to distinguish right from wrong and adhere to the right. He has [does not have] the mental capacity to understand and participate in any action contemplated in his case. The disclosure to the patient of information relative to his mental health would not [would] adversely affect the patient's mental health. Available research data has indicated that the predication of violence and antisocial behavior cannot be done with accuracy. If discharged to his own custody, he is not [is] expected to constitute a menace to himself or to the public safety. He is not [is] likely to become a public charge."

16.5.3. Psychological Testing: When used for diagnostic purposes, psychological testing must reflect the ethnic and cultural characteristics of the population represented by the detainee. Evaluators shall use culturally sensitive testing instruments. Test reports are considered confidential and will only be released to INS staff with a need to know.

16.6. Suicide Risk Evaluation and Prevention. Detainees may be identified as being at risk for suicide through the initial screening process, daily observation, self-referral or by an INS officer.position recommendations to INS (see Suicide Prevention SOP 16.5.1). The key components of the Suicide Prevention Program will include the following:

X**Identification.** Those at risk for suicide should be identified based on the Mental Health Screening Form (DIHS-843), referrals from other health providers, self-identified, or by an INS officer or security guard.

X**Housing.** A detainee that has been identified as being suicidal shall not be left alone. An appropriate level of direct observation must be maintained. Staffing issues will be taken into consideration. However, if the detainee is identified as being at immediate risk, direct observation shall be maintained at all times and the room where the detainee is housed shall be as near suicide-proof as possible (i.e. without protrusions or materials that would enable the detainee to hang or injure him/herself).

X**Training.** All DIHS staff members who work with detainees will be trained to recognize verbal and behavioral cues that indicate a potential suicide risk. New staff members will complete this training before they are allowed to serve in the facility alone. All employees should receive this training at least twice per year.

X**Assessment.** Assessment is conducted by a qualified medical/mental health professional that designates the detainee's level of suicide risk.

X**Monitoring.** The Suicide Observation Checklist (DIHS 835) will be used to monitor potentially suicidal detainees. The Suicide Observation SOP 16.5 will be followed.

16.7. Therapeutic Restraints. Therapeutic restraints refer to measures taken as part of medical or mental health treatment that are designed to confine a patient's bodily movements. Therapeutic restraints may be of the physical type (leather cuffs) or of the chemical type (medications). The least restrictive treatment alternative will always be used. The behavior of the detainee with a mental illness that becomes aggressive, destructive, or otherwise unmanageable must be controlled, not only for the benefit and safety of others, but also for the detainee's own welfare. Seclusion is considered less restrictive than restraints. If it is necessary to subject a detainee to physical and/or chemical restraints for medical and/or mental health reasons, the use of therapeutic restraints shall be subject to close scrutiny. Under no circumstances shall a detainee be subjected to chemical and/or physical restraints for purposes of discipline or convenience, such as for transportation of detainees unless a court order has been obtained.

16.7.1. Utilization of Physical Restraints. Detainees may be subjected to physical restraints for medical or mental health purposes. A written order of a physician, psychiatrist, or psychologist is required prior to the use of physical restraints. When one of the above-mentioned providers is not present in the facility, a telephone order from a physician/psychiatrist/psychologist to an on-duty medical provider may suffice. In cases where a telephone order for physical restraints is implemented, the physician, psychiatrist, or psychologist must see and evaluate the patient and cosign the order within one hour. The written order for restraints shall be for a limited and specific period of time not to exceed 12 hours. The order shall document the necessity of the restraints.

Restraints may include fleece lined leather, rubber or canvas hand and leg restraints, and straitjackets (metal or hard plastic devices such as handcuffs and leg shackles should not be used). Detainees should not be restrained in an unnatural position (i.e. hog-tied, face down, or spread-eagle). The Medical Observation of Detainee in Restraints Flow-sheet should be started in which visual observation of the detainee is done every 15 minutes. Both the health authority and person legally responsible for the camp should receive daily reports on the frequency and use of physical restraints.

Restraints will be used only after all other less restrictive options have been exhausted and until the detainee regains better control of his/her behavior and/or is transported to the hospital. When physical restraints are used, there must be clear, documented evidence in the patient's medical record which states, that less restrictive treatment was used and was unsuccessful in stopping the detainee's harmful behavior. Please refer to Restraints SOP 16.6.1.

16.7.2. Utilization of Chemical Restraints. Detainees may be subject to chemical restraints with forced psychotropic medications following the guidelines of the National Commission on Correctional Health Care (J-65 Attachment 1). Forced psychotropic medications should be employed only under the following conditions:

X The detainee poses an imminent or immediate threat to self or others
X All less restrictive or intrusive measures have been employed and judged by the treating physician, psychiatrist, or psychologist to be inadequate
X The physician, psychiatrist, or psychologist clearly documents in the health record the detainee's condition, the threat posed, and the reason for the proposed forcing of medication, including other methods attempted

X In all cases, except emergencies, a second opinion with another psychiatrist, psychologist, or physician is obtained prior to forcing medication and the treatment plan addresses withdrawal of the medication as soon as possible

X Where possible, orders for forced medications are reviewed through an independent psychiatric evaluation to safe guard the detainee's due process

16.8. Substance Dependence Treatment. Detainees that are determined to have substance dependence may be educated, treated and monitored on-site. Those experiencing intense intoxication and/or withdrawal that require intensive medical monitoring and related medical treatment will be referred to an appropriate facility for treatment. Outpatient treatment and monitoring of detainees with substance dependence may be provided on site by DIHS staff, in consultation with the appropriate specialist as necessary.

16.9. Sexual Assault. Sexual assault is defined, as an act of a sexual nature in which an individual is coerced to engage in sexual activity against his or her will. A detainee that is sexually assaulted shall be evaluated and treated through community resources depending on the specific need. With the detainee's consent, a referral may be made to a community facility for treatment and gathering of evidence as specified in local operating procedures. Mental health follow-up shall be provided as necessary. In INS SPCs, the HSA shall be responsible for making recommendations to the INS OIC, regarding the separation of the detainee from his/her assailant to minimize the potential for future assault and victimization. Such recommendations shall be documented on the Detainee Special Need(s) Form (DIHS 819).

16.10. Hunger Strike. Any detainee who has declared a hunger strike must be assessed by a mental health provider. The purpose of this assessment is to determine if the detainee is competent to make the decision to hunger strike.